STATE OF MICHIGAN

COURT OF APPEALS

DEBORAH COMPTON,

Plaintiff-Appellant/Cross-Appellee,

v

HELEN ALEXANDRA PASS, M.D., JANE E. PETTINGA, M.D., and WILLIAM BEAUMONT HOSPITAL,

Defendants-Appellees/Cross-Appellants.

UNPUBLISHED
August 22, 2006

No. 260362
Oakland Circuit Court
LC No. 2003-048275-NH

Before: Kelly, P.J. and Markey and Meter, J.J.

PER CURIAM.

In this medical malpractice action, plaintiff Deborah Compton appeals as of right a judgment of no cause of action entered in favor of defendants Alexandra Helen Pass, M.D., Jane E. Pettinga, M.D., and William Beaumont Hospital. On appeal and cross-appeal, the parties raise several issues, one of which we consider dispositive. We reverse the trial court's order denying defendants' motion for summary disposition on the basis of causation, remand for entry of an order granting summary disposition in defendants' favor, and vacate all orders the trial court entered subsequent to the reversed order.

I. Facts

This claim arises out of an axillary lymph node dissection[1] treatment for cancer that Drs. Pettinga and Pass performed on plaintiff at Beaumont Hospital in April 2001. Plaintiff, who sought medical care from Dr. Pass for breast cancer, alleged that defendants surgically removed at least 18 of her right axillary lymph nodes as part of NSABP[2] Clinical Trial B-32, without obtaining her informed consent. Plaintiff alleged that if she had been properly informed, she

[1] Axillary lymph node dissection is the surgical removal of the fat pad that contains the lymph nodes under the arm.

[2] National Surgical Adjuvant Breast and Bowel Project.

would have opted not to participate in the B-32 trial, but instead would have chosen to undergo the sentinel node removal.[3] Plaintiff alleged that, as a result of defendants' failure to properly provide her with informed consent, she suffers permanent axillary cording[4] and lymphedema.[5]

In their motion for summary disposition, defendants argued that pursuant to MCL 600.2912a(2), plaintiff was required to establish a loss of opportunity to achieve a better result greater than 50 percent. Defendants asserted that all three of plaintiff's oncology experts, stated that the difference between lymphedema rates stemming from axillary dissection and sentinel node procedures is significantly less than 50 percent. Plaintiff responded contending that Beaumont Hospital's B-32 protocol "is the most crucial document in assessing the morbidity rates associated with axillary node dissections versus sentinel node biopsies."[6] Plaintiff asserted that, according to the protocol, 82 percent of women undergoing the axillary node dissection experience some arm morbidity while the morbidity associated with the sentinel node biopsy is minimal to none. Plaintiff also cited the affidavit of her expert Burt M. Petersen, M.D., wherein he asserted that he agrees with these morbidity rates. Plaintiff also cited the deposition testimony of Vernon K. Sondak, M.D., stating that he agreed with the 82 percent morbidity rate identified in the protocol.[7] Plaintiff further argued that she did not simply allege that she suffered "arm swelling," but alleged that she was caused pain, suffering, emotional distress, etc. associated with axillary cording and lymphedema. The trial court denied defendants' motion. On the record, the trial court stated that because plaintiff "alleged and testified at deposition that she suffers from multiple affects [sic] after the axillary dissection the Court finds there are questions of fact for the jury."

II. Analysis

A. Standard of Review

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[3] In the sentinel node procedure, material is injected into the area of the tumor. Only the nodes that accumulate the material are removed.

[4] Axillary cording is when the ligaments and tendons scar, shrink, and become less mobile.

[5] Lymphedema is a temporary or permanent swelling of the arm.

[6] The B-32 protocol is a document designed to set forth the background and goals for "A Randomized, Phase III Clinical Trial to Compare Sentinel Node Resection to Conventional Axillary Dissection in Clinically Node-Negative Breast Cancer Patients." The portion of the protocol on which plaintiff relies is the background for the study. The protocol states that "[o]ne of the primary aims of the B-32 trial is to determine if the morbidity associated with sentinel node resection is significantly less than that associated with conventional axillary dissection."

[7] The trial court struck Dr. Petersen's testimony with respect to the probability of developing lymphedma after an axillary node procedure as opposed to a sentinel procedure. Further, Dr. Sondak did not state that he agreed with the 82 percent figure. Rather, he stated that he agrees that "most women" undergoing axillary dissection have "a problem" afterward. On appeal, plaintiff does not rely on Dr. Sondak's testimony.

We review de novo a trial court's decision on a motion for summary disposition. *Dressel v Ameribank*, 468 Mich 557, 561; 664 NW2d 151 (2003). Summary disposition is proper under MCR 2.116(C)(10) if the documentary evidence submitted by the parties, viewed in the light most favorable to the nonmoving party, shows that there is no genuine issue regarding any material fact and the moving party is entitled to judgment as a matter of law. *Veenstra v Washtenaw Country Club*, 466 Mich 155, 164; 645 NW2d 643 (2002). The evidence we consider when reviewing this motion is the evidence available to the trial court at the time of the motion. *Pena v Ingham Co Rd Comm*, 255 Mich App 299, 313 n 4; 660 NW2d 351 (2003).

B. Causation

To establish a medical malpractice cause of action, a plaintiff must establish four elements: "(1) the appropriate standard of care governing the defendant's conduct at the time of the purported negligence, (2) that the defendant breached the standard of care, (3) that the plaintiff was injured, and (4) that the plaintiff's injuries were the proximate result of the defendant's breach of the applicable standard of care." *Craig v Oakwood Hosp*, 471 Mich 67, 86; 684 NW2d 296 (2004).

"To establish proximate cause, the plaintiff must prove the existence of both cause in fact and legal cause." *Weymers v Khera*, 454 Mich 639, 647; 563 NW2d 647 (1997). Expert testimony is essential to establish a causal link between the alleged negligence and the alleged injury. *Dykes v William Beaumont Hosp*, 246 Mich App 471, 476-482; 633 NW2d 440 (2001); *Thomas v McPherson Community Health Ctr*, 155 Mich App 700, 705; 400 NW2d 629 (1986). Further, in *Fulton v William Beaumont Hosp*, 253 Mich App 70, 83; 655 NW2d 569 (2002), this Court held that "MCL 600.2912a(2) requires a plaintiff to show that the loss of the opportunity to survive or achieve a better result exceeds fifty percent." In other words, to satisfy the proximate cause element in a medical malpractice action, the plaintiff must show that the difference between the plaintiff's initial opportunity to survive or achieve a better result and the plaintiff's opportunity following the malpractice is greater than fifty percent. *Id.* at 83-84. MCL 600.2912a(2) provides:

> In an action alleging medical malpractice, the plaintiff has the burden of proving that he or she suffered an injury that more probably than not was proximately caused by the negligence of the defendant or defendants. In an action alleging medical malpractice, the plaintiff cannot recover for loss of an opportunity to survive or an opportunity to achieve a better result unless the opportunity was greater than 50%.

On appeal, plaintiff contends that defendants argue only that plaintiff failed to demonstrate a greater than 50 percent chance of not suffering lymphedma, but plaintiff claimed to have suffered other arm problems resulting from the surgery. Indeed, both in defendants' motion for summary disposition and their brief on appeal, defendants only discuss lymphedema. Defendants' statement of the issue presented also mentions only lymphedema, not axillary cording, the other alleged injury. The appellant must identify his issues in his brief in the statement of questions presented. MCR 7.212(C)(5); *Grand Rapids Employees Independent Union v Grand Rapids*, 235 Mich App 398, 409-410; 597 NW2d 284 (1999). In their reply brief, defendants add an argument about axillary cording. However, reply briefs may contain only rebuttal argument, and raising an issue in a reply brief is not sufficient to properly present an

issue for appeal. MCR 7.212(G); *Maxwell v Dep't of Environmental Quality*, 264 Mich App 567, 576; 692 NW2d 68 (2004). Nonetheless, in the interest of judicial economy, we address both alleged injuries.[8]

With regard to lymphedema, defendants contend that plaintiff's expert Robert Steele, M.D. testified that he agreed with the B-32 protocol indicating that the percent chance of lymphedema alone following the axillary node procedure is 18 percent. He opined that the chance of lymphedema following the sentinel node procedure is from zero to three percent. Defendants also note that Allen Meek, M.D. testified that plaintiff's chance of developing arm lymphedema after the axillary node dissection was 35 percent. Dr. Meek testified that the chance of lymphedema following the sentinel node procedure was five percent or less. With regard to axillary cording, defendants assert in their reply brief that Dr. Meek testified that plaintiff's risk of axillary cording with a sentinel node procedure was "less than 5 percent." He testified that her risk of axillary cording following an axillary node dissection would be "as high as 35 percent" and that a "good average number is somewhere between 12 and 15." According to this testimony, plaintiff did not lose an opportunity to achieve a better result that was greater than 50%. *Fulton, supra* at 82-84.

Plaintiff, on the other hand, relies on the portion of the B-32 protocol, which states,

> Arm morbidity is common with axillary dissection, and 82% of women undergoing it experience at least one arm problem, with associated psychological distress ranging from 17-50%. One study reported the following frequencies of adverse events in patients: numbness in 70%, pain in 33%, weakness in 25%, arm swelling in 18%, stiffness in 10% and reduced quality of life in 39%. . . .

Satisfying the need for expert testimony, plaintiff relies on the affidavit of Dr. Petersen, who attested, in agreement with the protocol, that the "morbidity rate associated with axillary node dissection is 82%, and is only about 3% with a sentinel node biopsy." Petersen's affidavit is dated November 11, 2004. However, an order precluding him from offering "any evidence regarding the statistical probability of developing lymphedema following an axillary dissection versus a sentinel node procedure" was entered November 8, 2004.[9]

Plaintiff asserts that Dr. Petersen's affidavit is nonetheless sufficient because "[s]he also lost the opportunity to avoid the pain, axillary cording, weakness, pulling, and stinging of her arm that resulted from surgery. She lost the quality of life and psychological comfort that comes

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[8] Although this Court need not review issues raised for the first time on appeal, it may overlook preservation requirements if failure to consider the issue would result in manifest injustice, if consideration is necessary for a proper determination of the case, or if the issue involves a question of law and the facts necessary for its resolution have been presented. *Smith v Foerster-Bolser Constr, Inc*, 269 Mich App 424, 427; 711 NW2d 421 (2006).

[9] The trial court ruled that Petersen's testimony in this regard lacked a scientific basis. On appeal, plaintiff does not take issue with this ruling.

with having a healthy and useful right arm and hand." However, plaintiff specifically alleged that she suffered lymphedema and axillary cording. Her complaint states:

> That as a direct and proximate result of the negligence of the Defendants herein, Plaintiff Deborah Compton has been caused to suffer severely disabling and permanent injuries. She now suffers from painful and permanent axillary cording, and from permanent lymphedema, which causes a painful swelling in her right arm, elbow joint, wrist, hand, fingers, and finger joints. She must wrap her right arm with surgical bandages from shoulder to fingertips at all times to attempt to minimize the painful swelling. Additionally, she must place her arm in a mechanical pressure pump several times per day for the swelling. She has to live with severe restrictions and limitations with regard to the use of her right arm from her axillary cording and lymphedema as follows . . . .

In *Weymers, supra* at 654-658, our Supreme Court held that when a plaintiff alleged kidney injury, she could not recover for pulmonary injury, despite her general allegation of pain and suffering. Here, we have a similar situation in which plaintiff alleged axillary cording and lymphedema and pain and suffering associated with these injuries, yet she relies on statistical evidence to demonstrate that defendants' negligence caused her to suffer arm morbidity generally. Because plaintiff's alleged injuries were lymphedema and axillary cording, she must offer proof that defendants' negligence caused these injuries, not morbidity generally, which could constitute any number of various other injuries not alleged or sustained.

Plaintiff also argues that: "[w]ith respect to the second sentence of § 2912a(2), Plaintiff's claim would be valid because this sentence does not concern itself with the specific injury that Plaintiff already suffered (as Defendants' argument suggests), but with the 'opportunity' to achieve a 'better result.' " Plaintiff argues that according to this reading of the statute, she need only show that her opportunity to achieve a better result generally exceeded 50 percent and she need not show that her opportunity to avoid the injuries actually suffered exceeded 50 percent. Under plaintiff's interpretation of MCL 600.2912a(2), a plaintiff who alleged specific injuries would never be required to prove that her chance of avoiding the specifically alleged injuries exceeded 50 percent; rather, she would merely have to prove that her chance of avoiding any injury, even one not sustained, exceeded 50 percent. However, plaintiff cites no case law supporting her novel interpretation of MCL 600.2912a(2) and we decline to adopt it.

C. Conclusion

At the time the motion for summary disposition was heard, plaintiff failed to present any evidence that the alleged negligence was the proximate cause of her alleged injuries. Accordingly, we reverse the trial court's order denying defendants' motion for summary

disposition, remand for entry of an order granting summary disposition in defendants' favor, and vacate all orders entered subsequent to the reversed order.[10] We do not retain jurisdiction.

/s/ Kirsten Frank Kelly
/s/ Jane E. Markey
/s/ Patrick M. Meter

[10] Because our decision on this issue resolves the case as a whole, we need not address the other issues on appeal.